Mindset
Counseling Solutions

Intake Packet

First Name: _____ MI: _____ Last Name: _____

Birth Date (Month/ Date/ Year): ____/____/_____ Age: _____

Phone number: _____

Address: _____

Email: _____

How did you hear about Mindset? _____

Emergency Contact Name: _____ Phone number: _____

Describe the situation/symptoms for which you are seeking counseling and what you would like to accomplish:

_____

_____

How serious is your problem: _____Mild (briefly interrupts my ability to cope with life) _____Moderate (moderate difficulty coping with my life) _____Severe (very serious problem affecting all areas of my life)

Have you ever had previous counseling? _____Yes _____No

Have you ever been involved in: Baker Act, detox, or Marchman Act? (If yes, please describe)_____

_____

_____

Have you ever been previously diagnosed by a professional? (If yes, please describe)_____

_____

Describe any future plans (ex. where you see yourself in 5 years): _____

_____

Family History Please describe the closest relatives to you:

Name: Relationship (mother, father, etc.): Age: Living at home (yes or no):

_____

_____

_____

_____

_____

Are you single, married, divorced, separated, widowed? _____

(If applicable) Age when first married: _____ Number of marriages: _____

What is the longest romantic relationship you have been in?_____

Mother:

Highest grade completed in school: _____ Occupation: _____

Describe the relationship with your mother: _____

_____

Father:

Highest grade completed in school: _____ Occupation: _____

Describe the relationship with your father: _____

_____

Siblings:

Name: Describe relationship:

_____

_____

_____

_____

Has anyone in your family had a history of any of the following:

Current or past use of alcohol and /or drugs? _____

Legal involvement?_____

Mental illness?_____

History of physical/sexual/verbal abuse or domestic violence?_____

Any other pertinent history?_____

Health:

Primary care physician:_____

Have you had any surgeries, hospitalizations, major accidents, major illnesses? (If yes please describe)_____

_____

List any medication(s) you are taking:

Medication Name: Dose: Prescribed By:

_____

_____

_____

School/Work:

What is the highest grade you completed in school? _____

Describe your overall school experience?_____

_____

Describe your past/current occupation(s): _____

_____

Are you satisfied with your current job? _____

What activities do you do in your spare time? _____

What are your strengths? _____

_____

How many hours a day are you watching TV or internet? _____

Spiritual Background:

Please describe any religious/spiritual involvement: _____

_____

Are there any special religious or cultural considerations I should be aware of as we meet? (If so, please describe)

_____

Drug and Alcohol Use:

What substances do you use most often? _____

How often do you use (daily, weekly, monthly)?_____

When was the last time you used drugs/alcohol? _____

Have you ever tried to cut down your drug/alcohol use? _____

Do you crave drugs/alcohol? _____

Do you use drugs/alcohol despite having consequences (relationships conflict, legal issues, health issues, etc.)?

_____

Has someone close to you pointed out a problem with your drug/alcohol use? _____

Have you ever experienced withdrawal from stopping the use of drugs/ alcohol? _____

Have you ever experienced tolerance (needing more of the drug to get the same effect?) _____